

FOR STATE  
HEALTH DEPT.

12208

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

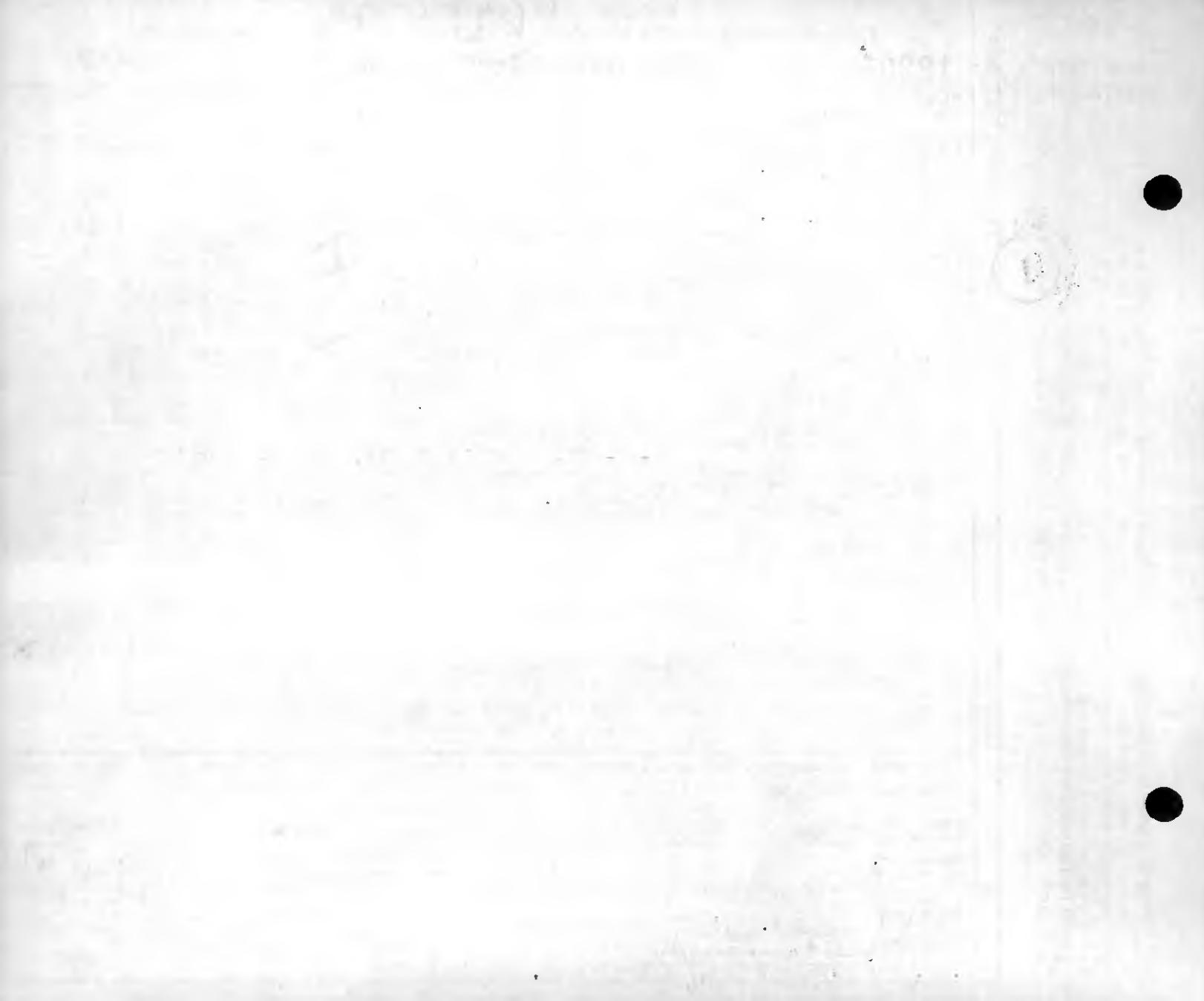
12219

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Mitchell</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN 1b <b>3 months</b>	
c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) <b>Pelham</b>		49-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Union Grove</b>		d. STREET ADDRESS <b>211 Cannon Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MATTHEW</b>		4. DATE OF DEATH Month <b>September</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>June 6, 1914</b>	
9. AGE (In years last birthday) yrs. <b>53</b>		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Mitchell County, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ammon Hall</b>		14. MOTHER'S MAIDEN NAME <b>Laura Powell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>253-05-4393</b>	
17. INFORMANT <b>Mattie Jordan, Pelham, Georgia</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Asthma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>9-19-67</b>	
ACTUAL SIGNATURE <b>Frank M. Anderson</b> M.D. EXAMINER'S NAME (Type) <b>FRANK M. Anderson MD.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>Sept. 19, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pelham Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pelham, Georgia</b>	
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 21 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12208

CERTIFICATE OF DEATH

12220

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. LENGTH OF STAY IN TB <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON, (Near Thomastown)</b> 05.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>NONE</b>		d. STREET ADDRESS <b>Route # 3</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Sophronia Murray Harris</b>		4. DATE OF DEATH Month <b>September</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9- 24- 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years and months) <b>82</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Not known by nearest relative</b>		14. MOTHER'S MAIDEN NAME <b>Not known by nearest relative</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-7392</b>	
17. INFORMANT <b>Mrs. Dorothy Chambers, 311 5th, Denton, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4221</b> IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic C.V.Dis.</b> DUE TO (c) <b>Hypochromic Anemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1</b> , 1967, to <b>Sept. 24</b> 1967 that (I) (we) last saw the deceased alive on <b>Sept. 23</b> 1967, and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Charles H. Stonestier</i>		22b. DATE SIGNED <b>Sept. 27 '67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C.H. STONESTIER, M.D.</b>		22d. ADDRESS <b>Greensboro, Maryland</b>	
23a. BURIAL, CREMATION, (Specify)	23b. DATE THEREOF <b>9- 28-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sandtown Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hillsboro, Md Caroline</b>
24. FUNERAL DIRECTOR <b>Charles W. Hill, Mortician, Denton, Md</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 3 1967</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

VR A15 (4)  
25M 1/67

1992

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12210

12221

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>		c. LENGTH OF STAY in lb <u>23 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5 Maple Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leolin</u> Middle <u>Howard</u> Last <u>Higgins</u>		4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1909</u>
9. AGE (In years last birthday) yrs. <u>57</u>		10. IF UNDER 1 YEAR Months <u>28</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lee Higgins</u>		14. MOTHER'S MAIDEN NAME <u>Cophonria Blake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-18-7632</u>	
17. INFORMANT <u>Mrs. Kathryn F. Higgins, Ridgely, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolus right</u> DUE TO (b) <u>7 Origin in right leg Varicose veins</u> DUE TO (c) <u>lyr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mild hypertension diastolic</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Arnold B. Plummer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Arnold B. Plummer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-1-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>East N. Market Dorch. Md.</u>
24. FUNERAL DIRECTOR <u>Frampton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>OCT 5 1967</u>	
ADDRESS <u>Federalburg, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12211						12222					
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>				c. LENGTH OF STAY IN 1b <b>40 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>				051	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>						d. STREET ADDRESS <b>None</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Gertrude</b> Last <b>Hutsen</b>						4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>19 67</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-27-1894</b>		9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Warren</b>						14. MOTHER'S MAIDEN NAME <b>Emma Porter</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Vaughn Hutsen Greensboro, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive Abdominal Metastasis</b> DUE TO (b) <b>Metastatic Adenocarcinoma of the</b> DUE TO (c) <b>Gall Bladder</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 1</b> , 19 <b>67</b> , to <b>Sept. 30</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>Sept. 29</b> , 19 <b>67</b> , and that death occurred at <b>Sept. 30</b> , 19 <b>67</b> , from causes and on the date stated above.											
22a. SIGNATURE <i>Charles H. Stonesifer</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 2 '67</b>			
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>						22d. ADDRESS <b>Greensboro, Md. 21639</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-4-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>				23d. LOCATION (City or Town) (County) (State) <b>Greensboro, Maryland</b>			
24. FUNERAL DIRECTOR <i>J.E. Boulain</i>						25a. REC'D BY REGISTRAR <b>OCT 5 1967</b>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

Caroline

Marjorie

Caroline

Greenwood

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Greenwood

Home

Home

Flanagan

Flanagan

Flanagan

Charles White

8-17-1934

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Home

Home

Home

Charles White

Home

UNITED STATES DEPARTMENT OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1934

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UNITED STATES DEPARTMENT OF THE ARMY

WASHINGTON, D. C.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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12223

Item #9 Film #0393 10/11/67 on

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DENTON</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First <u>KEHRLE</u> Middle <u>KEHRLE</u> Last 4. DATE OF DEATH <u>SEPT 28</u> 19 <u>67</u> Month <u>28</u> Day <u>1967</u> Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCT 27, 1898</u> 9. AGE (In years last birthday) <u>68</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> 11. BIRTHPLACE (State or foreign country) <u>N. J. USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEE DEMOTT</u> 14. MOTHER'S MAIDEN NAME <u>MARY GARRY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>ALFRED KEHRLE, DENTON</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic Congestive H at Failure</u> DUE TO (c) <u>Hypertensive arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>7yrs</u> <u>20yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		DATE SIGNED <u>9/30/67</u>	
EXAMINER'S NAME (Type) <u>Harold B. Plummer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 2, 1967</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HOLLYWOOD M. PK</u>		22d. LOCATION (City, town, or country) <u>UNION</u> (State) <u>N. J.</u>	
23. FUNERAL DIRECTOR <u>CHARLES MOORE</u> ADDRESS <u>DENTON, MD</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>OCT 4 1967</u>			

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

1975

100-100000

TO THE DIRECTOR OF THE BUREAU OF THE ARMY  
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY  
SUBJECT: [Illegible]

[Illegible handwritten text]

[Illegible handwritten text]

12213

## CERTIFICATE OF DEATH

12224

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA MARIE KROTEE</b>		4. DATE OF DEATH Month Day Year <b>SEPT 15 19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 27, 1893</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>GOTTFRIED LANG</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN SEIBERT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. LESLIE BARRETT, DENTON MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Vertebral fracture</b> DUE TO (b) <b>Anterior chest heart disease decem -</b> DUE TO (c) <b>punctured</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 HRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/15/67</b> , 19__, to <b>9/15/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>9/15/67</b> , 19__, and that death occurred at <b>8:00</b> P.M., from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>9/17/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>DENTON MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<b>BURIAL</b>	<b>SEPT 20, 1967</b>	<b>WOODLAWN</b>	<b>BALTIMORE MD</b>
24. FUNERAL DIRECTOR <b>CHARLES V. MOORE DENTON</b>		25a. REC'D BY REGISTRAR <b>SEP 19 1967</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12214

12225

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>		c. LENGTH OF STAY IN 1b <b>40 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) First <b>Burkett</b> Middle <b>Purnell</b> Last <b>Parker</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 8, 1888</b>
9. AGE (In years and birthday) <b>79</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Parker</b>		14. MOTHER'S MAIDEN NAME <b>Lou Upsher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Madeline Fountain Ridgely, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C.V.Dis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 10, 1966</b> , to <b>Sept. 30, 1967</b> that (I) (we) last saw the deceased alive on <b>Sept. 30, 1967</b> , and that death occurred at <b>10</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <i>Charles H. Stonesifer</i>		22b. DATE SIGNED <b>Oct. 2 '67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Md. 21639</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10- 3-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Chestertown, Md.</b>	
24. FUNERAL DIRECTOR <i>J. E. Boulais</i>		25a. REC'D BY REGISTRAR <b>OCT 5 1967</b>	
ADDRESS <i>Greensboro, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



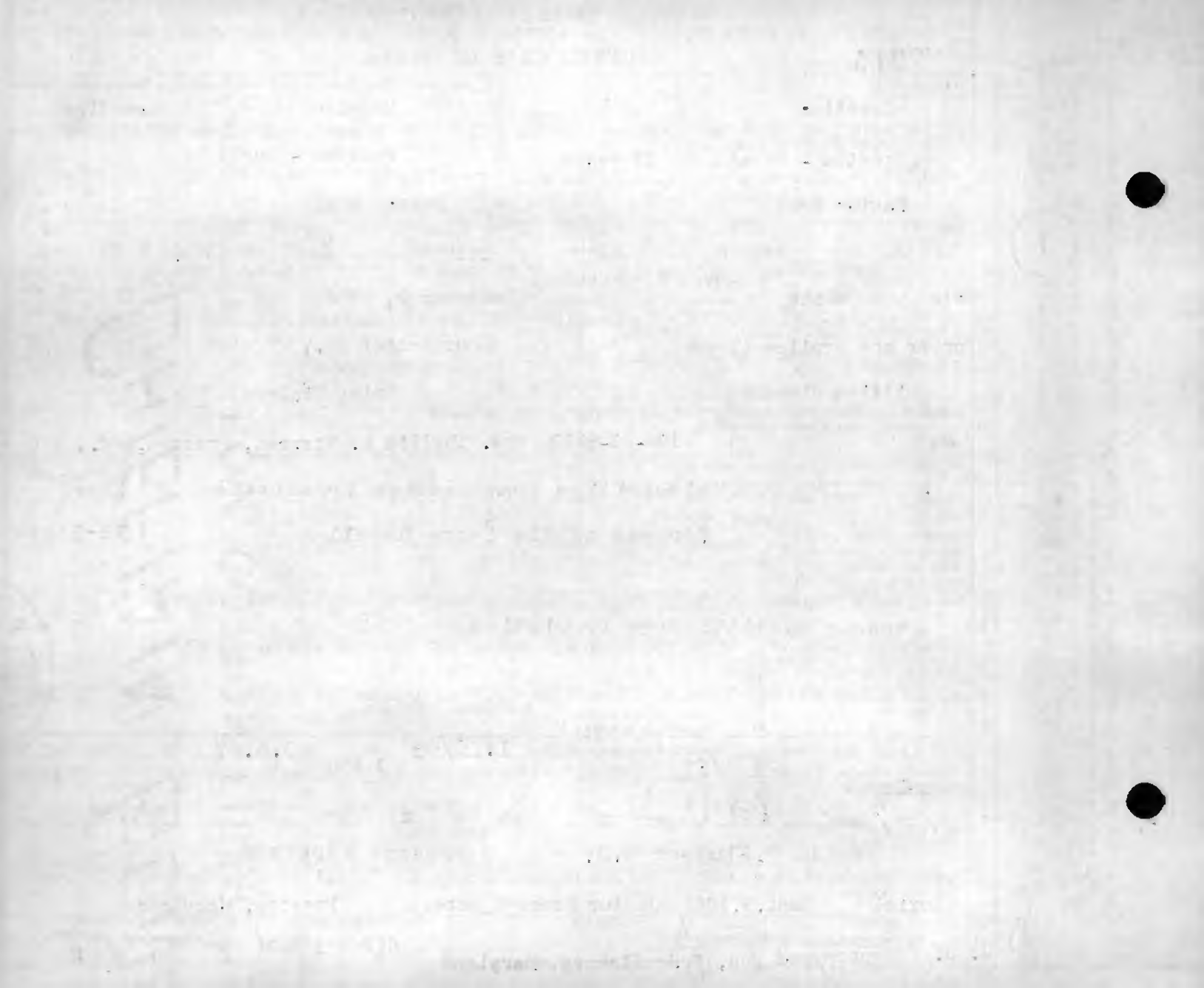


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12215 CERTIFICATE OF DEATH 12226									
1. PLACE OF DEATH a. COUNTY <b>Caroline</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Newton Road</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b> d. STREET ADDRESS <b>Newton Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>BRANCH</b> Middle <b>EDWARD</b> Last <b>STEVENS</b>					4. DATE OF DEATH Month <b>September</b> Day <b>6</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 2, 1908</b>		9. AGE (In years last birthday) <b>58 yrs.</b> IF UNDER 1 YEAR: Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer and Broiler Grower</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Stevens</b>					14. MOTHER'S MAIDEN NAME <b>Daisy Vickers</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>199-03-9273</b>		17. INFORMANT <b>Mrs. Phyllis L. Stevens, Preston, Md., RFD</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malnutrition from Massive Irradiation</b> <b>1538</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Sarcoma of the large bowell</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic cystitis from irradiation</b>								INTERVAL BETWEEN ONSET AND DEATH <b>12 yrs</b> <b>12-13 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1/28/55</b> , 19____, to <b>9.6.67</b> , 19____, that (I) (we) last saw the deceased alive on <b>9/6/67</b> , 19____, and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>B. Plummer</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>9/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arild B. Plummer M.D.</b>					22d. ADDRESS <b>Preston Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 9, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Junior Order Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Preston, Maryland</b>			
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Frederick, Maryland</b>					25a. REC'D BY REGISTRAR <b>SEP 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12216

CERTIFICATE OF DEATH

12227

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>		d. STREET ADDRESS <b>None</b>	
3. NAME OF DECEASED (Type or print) <b>Jake</b> First <b>Thomas</b> Middle <b>Thomas</b> Last		4. DATE OF DEATH Month <b>9</b> Day <b>9</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-1891</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Fireman Pet Milk Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>No Record</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-01-7097</b>	
17. INFORMANT <b>Mithhell Thomas Greensboro, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular</b> DUE TO (c) <b>Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 10, 1965</b> , to <b>Sept. 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Sept. 8, 1967</b> , and that death occurred at <b>9-11-67</b> M, from causes and on the date stated above.			
22a. SIGNATURE <i>Charles H. Stonesifer</i>		22b. DATE SIGNED <b>9-11-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>9-12-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	23d. LOCATION (City or Town) (County) (State) <b>Greensboro, Maryland</b>
24. FUNERAL DIRECTOR <b>J. E. Boulais</b>		25a. REC'D BY REGISTRAR <b>SEP 14 1967</b>	
ADDRESS <b>Greensboro, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1915

Continued from page 1

Serial	Date	Particulars	Debit	Credit	Balance
1	Jan 1	Balance forward			100.00
2	Jan 5	By Cash		50.00	150.00
3	Jan 10	To Cash	25.00		125.00
4	Jan 15	By Cash		75.00	200.00
5	Jan 20	To Cash	100.00		100.00
6	Jan 25	By Cash		50.00	150.00
7	Jan 30	To Cash	75.00		75.00
8	Feb 1	By Cash		100.00	175.00
9	Feb 5	To Cash	50.00		125.00
10	Feb 10	By Cash		75.00	200.00
11	Feb 15	To Cash	100.00		100.00
12	Feb 20	By Cash		50.00	150.00
13	Feb 25	To Cash	75.00		75.00
14	Feb 28	By Cash		100.00	175.00
15	Mar 1	To Cash	50.00		125.00
16	Mar 5	By Cash		75.00	200.00
17	Mar 10	To Cash	100.00		100.00
18	Mar 15	By Cash		50.00	150.00
19	Mar 20	To Cash	75.00		75.00
20	Mar 25	By Cash		100.00	175.00
21	Mar 30	To Cash	50.00		125.00
22	Mar 31	By Cash		75.00	200.00
23	Apr 1	To Cash	100.00		100.00
24	Apr 5	By Cash		50.00	150.00
25	Apr 10	To Cash	75.00		75.00
26	Apr 15	By Cash		100.00	175.00
27	Apr 20	To Cash	50.00		125.00
28	Apr 25	By Cash		75.00	200.00
29	Apr 30	To Cash	100.00		100.00
30	Apr 31	By Cash		50.00	150.00
31	May 1	To Cash	75.00		75.00
32	May 5	By Cash		100.00	175.00
33	May 10	To Cash	50.00		125.00
34	May 15	By Cash		75.00	200.00
35	May 20	To Cash	100.00		100.00
36	May 25	By Cash		50.00	150.00
37	May 30	To Cash	75.00		75.00
38	May 31	By Cash		100.00	175.00
39	Jun 1	To Cash	50.00		125.00
40	Jun 5	By Cash		75.00	200.00
41	Jun 10	To Cash	100.00		100.00
42	Jun 15	By Cash		50.00	150.00
43	Jun 20	To Cash	75.00		75.00
44	Jun 25	By Cash		100.00	175.00
45	Jun 30	To Cash	50.00		125.00
46	Jun 31	By Cash		75.00	200.00
47	Jul 1	To Cash	100.00		100.00
48	Jul 5	By Cash		50.00	150.00
49	Jul 10	To Cash	75.00		75.00
50	Jul 15	By Cash		100.00	175.00
51	Jul 20	To Cash	50.00		125.00
52	Jul 25	By Cash		75.00	200.00
53	Jul 30	To Cash	100.00		100.00
54	Jul 31	By Cash		50.00	150.00
55	Aug 1	To Cash	75.00		75.00
56	Aug 5	By Cash		100.00	175.00
57	Aug 10	To Cash	50.00		125.00
58	Aug 15	By Cash		75.00	200.00
59	Aug 20	To Cash	100.00		100.00
60	Aug 25	By Cash		50.00	150.00
61	Aug 30	To Cash	75.00		75.00
62	Aug 31	By Cash		100.00	175.00
63	Sep 1	To Cash	50.00		125.00
64	Sep 5	By Cash		75.00	200.00
65	Sep 10	To Cash	100.00		100.00
66	Sep 15	By Cash		50.00	150.00
67	Sep 20	To Cash	75.00		75.00
68	Sep 25	By Cash		100.00	175.00
69	Sep 30	To Cash	50.00		125.00
70	Sep 31	By Cash		75.00	200.00
71	Oct 1	To Cash	100.00		100.00
72	Oct 5	By Cash		50.00	150.00
73	Oct 10	To Cash	75.00		75.00
74	Oct 15	By Cash		100.00	175.00
75	Oct 20	To Cash	50.00		125.00
76	Oct 25	By Cash		75.00	200.00
77	Oct 30	To Cash	100.00		100.00
78	Oct 31	By Cash		50.00	150.00
79	Nov 1	To Cash	75.00		75.00
80	Nov 5	By Cash		100.00	175.00
81	Nov 10	To Cash	50.00		125.00
82	Nov 15	By Cash		75.00	200.00
83	Nov 20	To Cash	100.00		100.00
84	Nov 25	By Cash		50.00	150.00
85	Nov 30	To Cash	75.00		75.00
86	Nov 31	By Cash		100.00	175.00
87	Dec 1	To Cash	50.00		125.00
88	Dec 5	By Cash		75.00	200.00
89	Dec 10	To Cash	100.00		100.00
90	Dec 15	By Cash		50.00	150.00
91	Dec 20	To Cash	75.00		75.00
92	Dec 25	By Cash		100.00	175.00
93	Dec 30	To Cash	50.00		125.00
94	Dec 31	By Cash		75.00	200.00
95	Jan 1, 1916	Balance forward			100.00

Continued on page 2

1915

Continued from page 1

Serial

Date

Particulars

Debit

Credit

Balance

1

Jan 1

Balance forward

100.00

2

Jan 5

By Cash

50.00

150.00

3

Jan 10

To Cash

25.00

125.00

4

Jan 15

By Cash

75.00

200.00

5

Jan 20

To Cash

100.00

100.00

6

Jan 25

By Cash

50.00

150.00

7

Jan 30

To Cash

75.00

75.00

8

Feb 1

By Cash

100.00

175.00

9

Feb 5

To Cash

50.00

125.00

10

Feb 10

By Cash

75.00

200.00

11

Feb 15

To Cash

100.00

100.00

12

Feb 20

By Cash

50.00

150.00

13

Feb 25

To Cash

75.00

75.00

14

Feb 28

By Cash

100.00

175.00

15

Mar 1

To Cash

50.00

125.00

16

Mar 5

By Cash

75.00

200.00

17

Mar 10

To Cash

100.00

100.00

18

Mar 15

By Cash

50.00

150.00

19

Mar 20

To Cash

75.00

75.00

20

Mar 25

By Cash

100.00

175.00

21

Mar 30

To Cash

50.00

125.00

22

Mar 31

By Cash

75.00

200.00

23

Apr 1

To Cash

100.00

100.00

24

Apr 5

By Cash

50.00

150.00

25

Apr 10

To Cash

75.00

75.00

26

Apr 15

By Cash

100.00

175.00

27

Apr 20

To Cash

50.00

125.00

28

Apr 25

By Cash

75.00

200.00

29

Apr 30

To Cash

100.00

100.00

30

Apr 31

By Cash

50.00

150.00

31

May 1

To Cash

75.00

75.00

32

May 5

By Cash

100.00

175.00

33

May 10

To Cash

50.00

125.00

34

May 15

By Cash

75.00

200.00

35

May 20

To Cash

100.00

100.00

36

May 25

By Cash

50.00

150.00

37

May 30

To Cash

75.00

75.00

38

May 31

By Cash

100.00

175.00

39

Jun 1

To Cash

50.00

125.00

40

Jun 5

By Cash

75.00

200.00

41

Jun 10

To Cash

100.00

100.00

42

Jun 15

By Cash

50.00

150.00

43

Jun 20

To Cash

75.00

75.00

44

Jun 25

By Cash

100.00

175.00

45

Jun 30

To Cash

50.00

125.00

46

Jun 31

By Cash

75.00

200.00

47

Jul 1

To Cash

100.00

100.00

48

Jul 5

By Cash

50.00

150.00

49

Jul 10

To Cash

75.00

75.00

50

Jul 15

By Cash

100.00

175.00

51

Jul 20

To Cash

50.00

125.00

52

Jul 25

By Cash

75.00

200.00

53

Jul 30

To Cash

100.00

100.00

54

Jul 31

By Cash

50.00

150.00

55

Aug 1

To Cash

75.00

75.00

56

Aug 5

By Cash

100.00

175.00

57

Aug 10

To Cash

50.00

125.00

58

Aug 15

By Cash

75.00

200.00

59

Aug 20

To Cash

100.00

100.00

60

Aug 25

By Cash

50.00

150.00

61

Aug 30

To Cash

75.00

75.00

62

Aug 31

By Cash

100.00

175.00

63

Sep 1

To Cash

50.00

125.00

64

Sep 5

By Cash

75.00

200.00

65

Sep 10

To Cash

100.00

100.00

66

Sep 15

By Cash

50.00

150.00

67

Sep 20

To Cash

75.00

75.00

68

Sep 25

By Cash

100.00

175.00

69

Sep 30

To Cash

50.00

125.00

70

Sep 31

By Cash

75.00

200.00

71

Oct 1

To Cash

100.00

100.00

72

Oct 5

By Cash

50.00

150.00

73

Oct 10

To Cash

75.00

75.00

74

Oct 15

By Cash

100.00

175.00

75

Oct 20

To Cash

50.00

125.00

76

Oct 25

By Cash

75.00

200.00

77

Oct 30

To Cash

100.00

100.00

78

Oct 31

By Cash

50.00

150.00

79

Nov 1

To Cash

75.00

75.00

80

Nov 5

By Cash

100.00

175.00

81

Nov 10

To Cash

50.00

125.00

82

Nov 15

By Cash

75.00

200.00

83

Nov 20

To Cash

100.00

100.00

84

Nov 25

By Cash

50.00

150.00

85

Nov 30

To Cash

75.00

75.00

86

Nov 31

By Cash

100.00

175.00

87

Dec 1

To Cash

50.00

125.00

88

Dec 5

By Cash

75.00

200.00

89

Dec 10

To Cash

100.00

100.00

90

Dec 15

By Cash

50.00

150.00

91

Dec 20

To Cash

75.00

75.00

92

Dec 25

By Cash

100.00

175.00

93

Dec 30

To Cash

50.00

125.00

94

Dec 31

By Cash

75.00

200.00

95

Jan 1, 1916

Balance forward

100.00